Clearbill use only

Prenatal only _____ Homebirth _____ Hospital Birth _____ Facility _____

Boy _____ Girl _____ Weight _____ Notes_____ DOS _____

Auth _____ Req _____ App_____ LOA_____ Rate_____Paper_____

RIVER AND MOUNTAIN MIDWIVES, PLLC

SUSANRACHEL CONDON, LM AND SUSAN RANNESTAD, LM

Client Registration Form

CLIENT INFORMATION (as it appears on insurance)

Name (First) _____ (MI) _____ (Last) _____ Date_____

Address _____ City _____ State _____ Zip _____

Phone 1 _____ Phone 2 _____ Email _____

Date of Birth _____ Age _____ Soc Sec # _____ Marital Status _____

Returning Client: Yes ☐ No ☐ If Yes, List Year of Last Visit _____ (applies to GYN and Maternity care)

Visit: OB ☐ GYN ☐ First child? Yes ☐ No ☐ Last Menstrual Period _____ Estimated Due Date _____

Partners Name_____ Date of Birth _____ Soc. Sec #_____

Phone 1 _____ Phone 2 _____ Email _____

PRIMARY INSURANCE **PLAN SOURCE**: Employer ☐ NY State of Health ☐ Medicaid ☐ Other ☐

Insurance Co _____ Plan Name _____ Effective _____

NY State of Health Plan Metal Level: Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Catastrophic ☐

Your Policy ID _____ Group # _____ Plan Type: Individual ☐ Family ☐

If plan is through an Employer is plan: Self Funded ☐ Fully Insured ☐ Provider Services Phone _____

In-Network: Deductible _____ Co-insurance _____Copay_____ Max Out of Pocket_____

Out-of-Network: Deductible _____ Co-insurance _____Copay_____ Max Out of Pocket_____

Policy Holder: Self ☐ Spouse ☐ Partner ☐ Parent ☐ Other ☐ (If self, skip next two lines)

Policy Holder's Name _____ Primary's Date of Birth _____

Address: _____ City _____ State _____ Zip _____

SECONDARY INSURANCE **PLAN SOURCE**: Employer ☐ NY State of Health ☐ Medicaid ☐ Other ☐

Insurance Co _____ Plan Name _____ Effective _____

NY State of Health Plan Metal Level: Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Catastrophic ☐

Your Policy ID _____ Group # _____ Plan Type: Individual ☐ Family ☐

If plan is through an Employer is plan: Self Funded ☐ Fully Insured ☐ Provider Services Phone _____

In-Network: Deductible _____ Co-insurance _____Copay_____ Max Out of Pocket_____

Out-of-Network: Deductible _____ Co-insurance _____Copay_____ Max Out of Pocket_____

Policy Holder: Self ☐ Spouse ☐ Partner ☐ Parent ☐ Other ☐ (If self, skip next two lines)

Policy Holder's Name _____ Primary's Date of Birth _____

Address: _____ City _____ State _____ Zip _____

PAYMENT INFORMATION

Global Fee: $**10,000** Deposit $ _____ Date _____ Discounted balance of $8,000 due by 36 wks pending insurance payment.
Other financial arrangements are workable per financial policies and insurance coverage.

I hereby authorize my provider to share this information with Clearbill. I also authorize Clearbill to request clinical information related to my care and to share this with insurance companies as part of Clearbill's efforts to obtain benefit information, authorization and to aid in claims processing. I acknowledge that while Clearbill will make an educated effort to obtain accurate information and strive to obtain payment from insurance on behalf of my care, payment to my provider is ultimately my responsibility.

Signature: _____ Date: _____